

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Daisy Belle Crouch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 28, 1980</b>			2b. HOUR <b>1:50</b> P M				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>September 23, 1881</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>98</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD				
10 CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital, Inc</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>General Delivery</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Alfred Walbert</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ? Copper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>-</b>		17 INFORMANT ADDRESS <b>Hospital Records-Chestertown, Maryland 21620</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>① Metabolic acidosis ② Atherosclerotic Heart Disease ③ Senility</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>February 27, 1980</b> , to <b>February 28, 1980</b> , that (I) (we) last saw the deceased alive on <b>February 28, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>K. K. Wun</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/3/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kin Kue Wun, M.D.</b>			22e. ADDRESS <b>Chestertown, Maryland 21620</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3-1-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESLEY CHAPEL CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rock Hall Kent MD</b>			
24 FUNERAL DIRECTOR NAME <b>HELFENBEIN HUBBARD</b>			ADDRESS <b>F.H. CHESTER MD</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffery H. Brady</b>		

Copy

Date

Through

Approved by \_\_\_\_\_

Initials

Name

U.S.A.

Signature

Print Name

Character Code

Name and Address of Hospital, Inc. Hospital

Manufacturer Name

Stock Held

General Delivery

Form

Filed

Received

Date

Order

To

10-10-70

Medical Records-Department, Maryland

Enclosure

February 2, 1971

February 2, 1971

Kim Lee C. H.

Department, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 4 6 7 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Mare Ca Shavone Cunningham</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 21 80</b>			2b. HOUR <b>4:10P M</b>				
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 24, 1979</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>0 7 28</b>		7 UNDER 24 HRS. HOURS MIN. <b>7 28</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>infant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #1 Box 233</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Alvin Lee Cunningham</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marica Eunice Thomas</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>				
16b. SOCIAL SECURITY NO <b>None</b>			17 INFORMANT ADDRESS <b>Hospital Records Chestertown, Maryland</b>			18. DATE SIGNED <b>2/21/80</b>				
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRIB DEATH SYNDROME</b> <b>7980</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PREMATURE BIRTH</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>February 21, 19 80</b> , to <b>February 21, 19 80</b> , that (I) (we) last saw the deceased alive on <b>February 21, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John L. Morgan, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2/21/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John L. Morgan, M.D.</b>						22e. ADDRESS <b>Chestertown, Maryland 21620</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/26/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharptown Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Nr. Rock Hall, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>James P. King</b>						ADDRESS <b>Rock Hall, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1980</b>		
						25b. REGISTRAR'S SIGNATURE <b>Robert McBrayer</b>				



Female  
Maryland  
Chesapeake  
Kent and Queen Anne's Hospital  
Rock Hill  
Baltimore  
Hospital Records  
Chesapeake, Maryland

February 11, 1900  
John L. ...  
February 11, 1900  
February 11, 1900

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 4 6 7 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
1. DECEASED NAME				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTHS DAYS HOURS MIN.			
Everett Joseph Kennedy				February 23, 1980				5:20A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male		White		MONTH DAY YEAR November 16, 1908		71		MONTHS DAYS		HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States				Kent MD.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's				Farmer		Self-Employed			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				17. INSIDE CITY LIMITS?		18. STREET ADDRESS					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Queen Anne's Barclay				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Box 47-A					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Joseph Kennedy				FIRST MIDDLE LAST Gora Jane Williamson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				214-18-5646		Hospital Records, Chestertown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Obstructive Pulmonary Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>February 5</u> , 19 <u>80</u> , to <u>February 23</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>February 23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Robert W. Farr M.D.</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Robert W. Farr M.D.				Chestertown, Maryland 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Burial		Feb. 26, 1980		Junior Order Cemetery		Preston, Maryland		FEB 26 1980			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE					
NAME		ADDRESS		FEDERALSBURG		Frampton-Hawkins Funeral Home		216 N. Main St.		FEB 26 1980	



**NAME:**

James Wilmer Lee

**DATE OF DEATH:**

February 19, 1980

**PLACE OF DEATH:**

Kent County

**SEE:** #03942, Baltimore City

**DRMH 2485 - Vit. Rec.**

TR/40



STATE  
OF NEW YORK  
COUNTY OF ...

IN SENATE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04676			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Ernest NMN Martin</u>										2a. DATE KNOWN OF DEATH ESTI- MATED <u>Feb. 10, 80</u>		2b. HOUR <u>10:30</u>	
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>4/28/1918</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <u>Feb. 10, 80</u>		7d. HOUR <u>10:30</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Kent</u>							
10. CITY OR TOWN OF DEATH <u>Chestertown</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Kent &amp; Queen Anne's Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Labor</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Kent</u>		13c. CITY OR TOWN <u>Worton</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>R.F.D. #1 Box 104</u>					
14. FATHER'S NAME FIRST MIDDLE LAST <u>Daniel Martin</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Annie Nicie White</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT ADDRESS <u>Hospital Records</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest secondary to aspirated</u> <u>4379</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>vomitus. Probably had cerebral vascular</u> (c) <u>hemorrhage or thrombosis. This was proceed by a</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>period when he had been unresponsive and comatose for about 8 hours.</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Robert W. Farr</u>				TITLE (SPECIFY) <u>Deputy</u> M.D. MEDICAL EXAMINER				DATE SIGNED <u>2-11-80</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Robert W. Farr M.D.</u>				ADDRESS <u>Chestertown, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>2/16/1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union United Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>R.F.D. Worton, Kent Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Samuel W. Waley</u> ADDRESS <u>Chestertown, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>FEB 13 1980</u>		25b. REGISTRAR'S SIGNATURE <u>History McCreedy</u>					

NOV 19 1964

Handwritten notes and markings on the right margin, including a large 'B' and other illegible scribbles.

Main body of the document containing several lines of extremely faint, illegible text, possibly a letter or report.

Handwritten signature or initials, possibly "C. T. G.", located in the lower right quadrant.

Small handwritten text or code at the bottom left corner.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 4 6 7 7			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
Hattie Virginia Miller				February 19, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Negro		May 18, 1896		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Kent County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent and Queen Anne's Hospital, Inc.		Housewife		-	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE				13c. CITY OR TOWN			
Maryland				Queen Anne Chestertown			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
John Wesley Goldsboro				Ida ? Harkless			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-16-3334		Hospital Records-Chestertown, Maryland 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
436- Right Cerebrovascular Accident							3 days
DUE TO, OR AS A CONSEQUENCE OF (b):							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c):							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
Aspiration Pneumonia; Anemia, unknown etiology							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 17, 1980, to February 19, 1980, that (I) (we) last saw the deceased alive on February 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Susan K. Ross M.D.						2/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Susan K. Ross, M.D.				Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/23/80		Mt. Pleasant Cem.		Pondtown, D.A. Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Edward F. Holloway, Jr., Millington, Md.				FEB 26 1980			

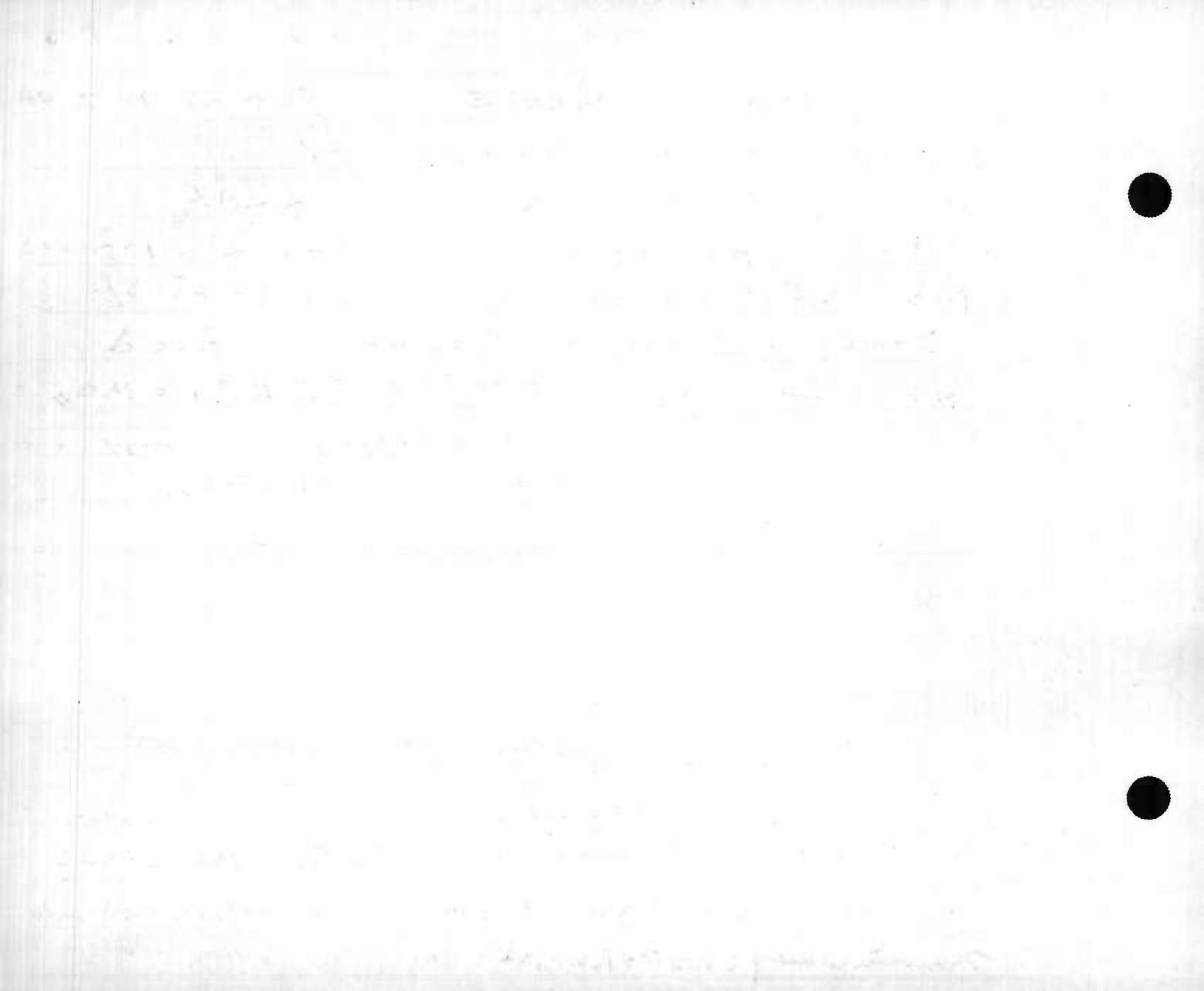


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

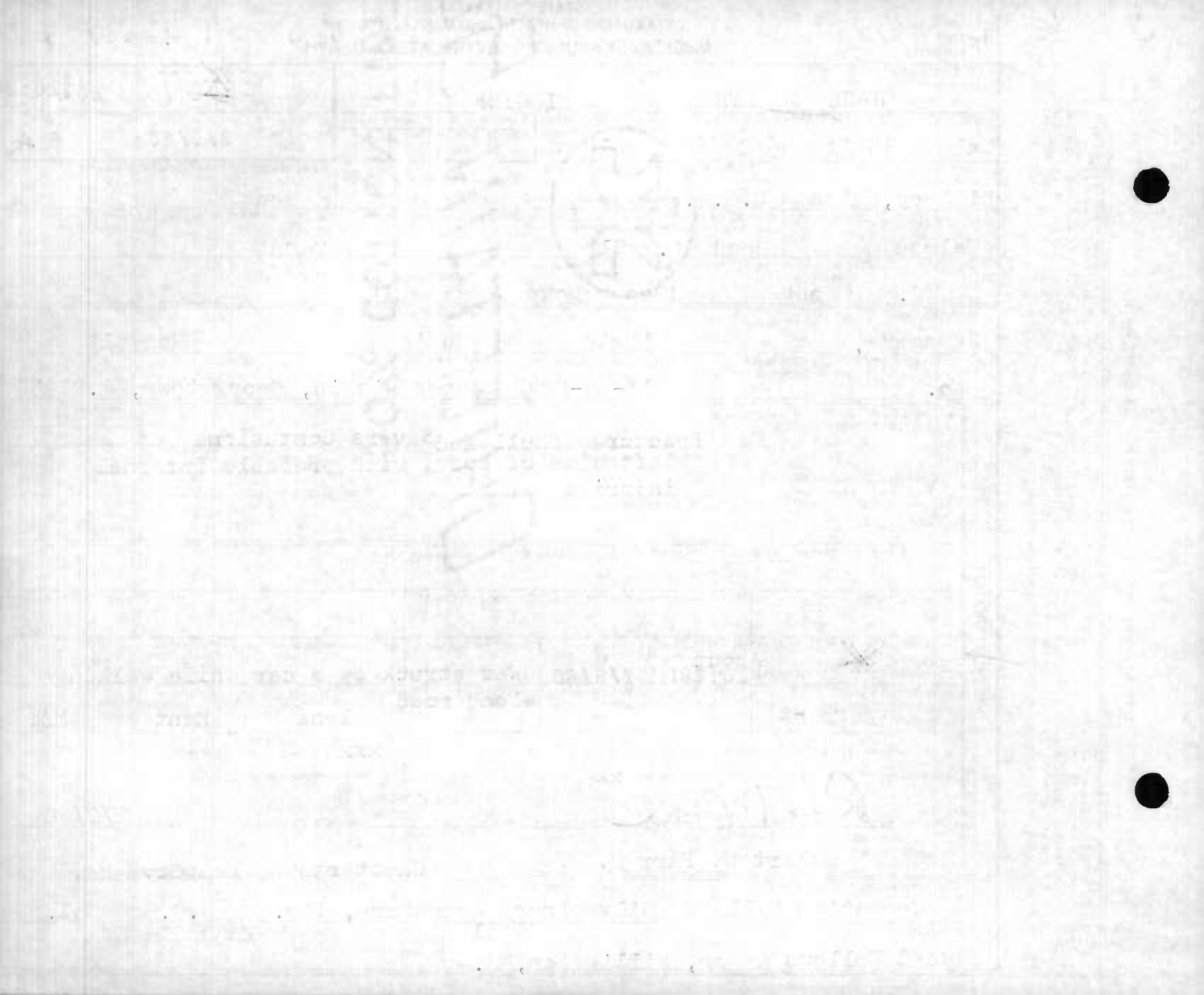
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80	04678								
FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR					
NORA							REESE		FEB.		29	1980	7:00 AM						
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 74 HRS					
FEMALE			BLACK			APR. 13, 1932			47			MONTHS		DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
MD.			U.S.A.						KENT										
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Chestertown			AT HOME			LABOR			Various										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS							
13a. STATE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		218 FRONT ST.							
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST										FIRST MIDDLE LAST									
JAMES JOHNSON										SARAH REED									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO										YES		MRS. ISABELLE WILSON		CENTREVILLE, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) CARDIOMYOPATHY										same wounds									
42553 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										CHRONIC ALCOHOL ADDICTION									
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
										P.M. 19									
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												STREET				STATE			
22a. I certify that (I) (this hospital) attended the deceased from										19 72		to		2/29		19 80			
saw the deceased alive on										NOV 16		19 79		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE										DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
C. G. GUTTERED BAUMANN														215780					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
C. G. GUTTERED BAUMANN										CHESTERTOWN, MD - 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY	
BURIAL										3-5-1980		JANE'S CEM.		CHESTERTOWN		KENT		STATE	
24 FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
James W. Day										MAR 19 1980		J. W. Day							
NAME										ADDRESS									
Chestertown, MD																			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04579	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JACK LYNCH RIGGINS</b>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <b>2/8 1980</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6/28/65</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>14</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>14</b>	IF UNDER 24 HRS. HOURS MIN <b>14</b>	21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2/9/80</b>		22. HOUR <b>10:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kittery, Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b> MD.					
10. CITY OR TOWN OF DEATH <b>Galena</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Road Rt. # 213</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Georgetown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Riffin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susie Woodall</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>				16b. SOCIAL SECURITY NO. <b>215-62-0242</b>		17. INFORMANT ADDRESS <b>James Riffin, Georgetown, Md. 21930</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull and Severe Contusions</b> DUE TO, OR AS A CONSEQUENCE OF <b>left side of body, with probable internal injuries</b> (b) <b>injuries</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING CAUSE OF DEATH <b>8147</b>				21b. TIME OF INJURY HOUR M. MONTH DAY YEAR <b>About 10:30 PM 2/8/80</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Was struck by a car while walking along road</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Galena</b>				21f. LOCATION CITY OR TOWN COUNTY STATE <b>Kent Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>R. L. Farr</b>				TITLE (SPECIFY) <b>Robert W. Farr M.D.</b>				DATE SIGNED <b>2/9/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Robert W. Farr M.D.</b> ADDRESS <b>Chestertown, Kent Co., Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2/11/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory, Wilm.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>N.C. Del.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Edward Fellows &amp; Son, Millington, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>FEB 14 1980</b>		26. REGISTRAR'S SIGNATURE <b>John P. McCready</b>					







MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>Edward</b>	Middle <b>STEINHILBER</b>	Last <b>STEINHILBER</b>	2a. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1980</b>		2b. HOUR <b>P</b> MIN <b>M</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov 27, 1886</b>		6. AGE (In years last birthday) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Kent</b> Md.	
10. CITY OR TOWN OF DEATH <b>Near Chestertown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>at home Fairlee Cove</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Medical Doctor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>Fairlee Cove</b>		14. FATHER'S NAME First <b>Michael</b> Middle <b>Steinhilber</b> Last <b></b>		15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Korn</b> Last <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes WW I</b>		16b. SOCIAL SECURITY NO. <b>210 36 6124</b>		17. INFORMANT <b>Robert Steinhilber</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b></b> Day <b></b> Year <b></b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> , 19 <b>78</b> , to <b>8/7</b> , 19 <b>79</b> , that (I) (we) lost the deceased alive on <b>8/7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Wayne D. Benjamin</b>				22c. DATE SIGNED <b>2/4/1980</b>			
22d. PHYSICIAN'S NAME (Type) <b>Wayne D. Benjamin</b>				22e. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/6/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Philadelphia, Pa.</b>	
24. FUNERAL DIRECTOR <b>Willis Wells</b>				25a. REC'D BY REGISTRAR <b>FEB 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b></b>	

PLANT INDUSTRY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

COUNTRY: \_\_\_\_\_

PLANT: \_\_\_\_\_

DESCRIPTION: \_\_\_\_\_

REMARKS: \_\_\_\_\_

DATE OF COLLECTION: \_\_\_\_\_

COLLECTOR: \_\_\_\_\_

LOCALITY: \_\_\_\_\_

PLANT: \_\_\_\_\_

DESCRIPTION: \_\_\_\_\_

REMARKS: \_\_\_\_\_

DATE OF COLLECTION: \_\_\_\_\_

COLLECTOR: \_\_\_\_\_

LOCALITY: \_\_\_\_\_

PLANT: \_\_\_\_\_

DESCRIPTION: \_\_\_\_\_

REMARKS: \_\_\_\_\_

DATE OF COLLECTION: \_\_\_\_\_

COLLECTOR: \_\_\_\_\_

LOCALITY: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 4 0 8 1														
1- FOR STATE REGISTRAR										REG. NO.														
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a DATE OF DEATH			MONTH		DAY		YEAR		2b HOUR					
Mary Lelia Walmsley										February 25, 1980									6:15 P.M.					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR			7 UNDER 24 HRS									
Female			White			May 14 1893			86			MONTHS			DAYS			HOURS			MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH															
Maryland			U.S.A.						Kent County MD.															
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																					
Chestertown			Kent And Queen Anne's Hospital																					
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY																					
Retired- Housewife			-																					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS								
Maryland										Queen Anne's		Sudlersville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT.#1								
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME														
Henry Franklin Gosman DEC.										Alethia NMN Campbell														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS												
No										220-28-2164		Hospital Records, Chestertown, Maryland 21620												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Idiosyncratic Rhythmic</i> (c) <i>marked family cardiac -</i> <i>ASCD</i>																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																								
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?					20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f LOCATION STREET CITY OR TOWN COUNTY STATE														
										February 19 80 February 25 80														
22a I certify that (I) (this hospital) attended the deceased from February 25 80, to February 25 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b SIGNATURE OF PHYSICIAN										DEGREE					22c. DATE SIGNED									
Patrick A. Molony, M.D.										M.D.														
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS														
Patrick A. Molony, M.D.										Chestertown, Maryland 21620														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION CITY OR TOWN COUNTY STATE									
Burial					2/29/80					Crumpton Cemetery					Crumpton Q.A. Md.									
24 FUNERAL DIRECTOR NAME										ADDRESS					25a DATE REC'D. BY REGISTRAR					25b REGISTRAR'S SIGNATURE				
Edward Fellows & Son, Millington, Md.										21651					MAR 3 1980					[Signature]				

BP



*[Faint, illegible handwriting in the center of the page, possibly a signature or a date.]*

*[Faint, illegible handwriting at the bottom of the page, possibly a signature or a date.]*

*[Faint, illegible handwriting at the very bottom of the page, possibly a signature or a date.]*